



1935 W. State Street STE 103
 Garland, TX 75042
 Ph: 972-372-9787
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ULTOMIRIS INFUSION ORDER FORM

PATIENT INFORMATION

Name:	DOB:
Allergies:	Weight: kg ; Height: in

DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> aHUS	ICD 10 Code: _____	<input type="checkbox"/> gMG classification II	ICD 10 Code: _____
<input type="checkbox"/> PNH	ICD 10 Code: _____	<input type="checkbox"/> gMG classification III	ICD 10 Code: _____
<input type="checkbox"/> Other: _____	ICD 10 Code: _____	<input type="checkbox"/> gMG classification IV	ICD 10 Code: _____

REQUIRED DOCUMENTATION

<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND Insurance Card <input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Meningococcal vaccine of BOTH MenACWY and MenB	<input type="checkbox"/> aHUS: documented (-) for Shiga toxin E. Coli and TTP <input type="checkbox"/> gMG: (+) anti-AChR AB; Mg-ADL score; EMG report <input type="checkbox"/> PNH: GPI deficiency flow cytometry analysis <input type="checkbox"/> MD enrolled in REMS program
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List Tried & Failed Therapies, including duration of treatment:

1) 2) 3)	<p><u>PA Guidance:</u> Failed Empaveli (pegcetacoplan) therapy. No HIGH risk of thrombosis or organ damage secondary to chronic hemolysis or high LDH activity. Is the patient transfusion dependent?</p>
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LOADING DOSE	MAINTENANCE DOSE
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<input type="checkbox"/> 40-59kg - 2400mg IV DAY 0 <input type="checkbox"/> 60-99kg - 2700mg IV DAY 0 <input type="checkbox"/> 100kg or > 3000mg IV DAY 0	<input type="checkbox"/> 40-59kg - 3,000mg IV Day 14 then every 8 weeks <input type="checkbox"/> 60-99kg - 3,300mg IV Day 14 then every 8 weeks <input type="checkbox"/> 100kg or > - 3,600mg IV Day 14 then every 8 weeks <input checked="" type="checkbox"/> Normal saline Flushes 10ml as needed (max 10 per infusion) <input type="checkbox"/> Premeds: _____
Infusion orders	1. Nurse to start/pause/remove PIV as needed OR access/deaccess PICC/PORT. 2. DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 500mL 0.9% NS)	
Refills: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses	

PRESCRIBER INFORMATION

Prescriber Name:	NPI #:
Office Phone:	Office Fax:
Office Email:	Date:
Prescriber Signature:	

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492